		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040436

Facility Name: Sterling Pavilion

Address: 105 E. 23Rd Street (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-4264 **Fax #** (815) 626-3254

IDPA ID Number: 363873072001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,286	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,286	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,583	9,386	3,189	22,158	8
9	SNF/PED					9
10	ICF	15,940	4,104		20,044	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,523	13,490	3,189	42,202	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.29%

D. How many bed-hold days during this year were paid by Public Aid? 2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 121 and days of care provided 2,943

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	158,010	11,506	7,080	176,596		176,596		176,596			1
2	Food Purchase		174,488		174,488		174,488	(2,102)	172,386			2
3	Housekeeping	116,553	34,131		150,684		150,684		150,684			3
4	Laundry	53,928	15,954		69,882		69,882		69,882			4
5	Heat and Other Utilities			131,844	131,844		131,844	953	132,797			5
6	Maintenance	51,587	46,448	38,584	136,619		136,619	1,393	138,012			6
7	Other (specify):*							609	609			7
8	**TOTAL General Services**	380,078	282,527	177,508	840,113		840,113	853	840,966			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,399,053	63,004	6,830	1,468,887		1,468,887	(1,102)	1,467,785			10
10a	Therapy	44,783	301	6,619	51,703		51,703		51,703			10a
11	Activities	95,981	1,670		97,651		97,651		97,651			11
12	Social Services	44,583		9,005	53,588		53,588		53,588			12
13	Nurse Aide Training											13
14	Program Transportation	7,555			7,555		7,555		7,555			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,591,955	64,975	22,454	1,679,384		1,679,384	(1,102)	1,678,282			16
	C. General Administration											
17	Administrative	100,773		35,000	135,773		135,773	74,152	209,925			17
18	Directors Fees											18
19	Professional Services			341,128	341,128		341,128	(262,919)	78,209			19
20	Dues, Fees, Subscriptions & Promotions			44,893	44,893		44,893	(34,185)	10,708			20
21	Clerical & General Office Expenses	41,391	4,124	41,413	86,928		86,928	31,620	118,548			21
22	Employee Benefits & Payroll Taxes			289,677	289,677		289,677	(235)	289,442			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,351	2,351		2,351	234	2,585			24
25	Other Admin. Staff Transportation			2,781	2,781		2,781	(264)	2,517			25
26	Insurance-Prop.Liab.Malpractice			71,654	71,654		71,654	(1,311)	70,343			26
27	Other (specify):*							26,458	26,458			27
28	**TOTAL General Administration**	142,164	4,124	828,897	975,185		975,185	(166,450)	808,735			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,114,197	351,626	1,028,859	3,494,682		3,494,682	(166,699)	3,327,983			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sterling Pavilion #0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,216	56,216		56,216	128,397	184,613			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,601	16,601		16,601	656,359	672,960			32
33	Real Estate Taxes			35,600	35,600		35,600	3,378	38,978			33
34	Rent-Facility & Grounds			694,895	694,895		694,895	(694,895)				34
35	Rent-Equipment & Vehicles			2,580	2,580		2,580	7,029	9,609			35
36	Other (specify):*							6,667	6,667			36
37	**TOTAL Ownership**			805,892	805,892		805,892	106,935	912,827			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	96,068	74,843	1,750	172,661		172,661	(3,455)	169,206			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,430	66,430		66,430		66,430			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	96,068	74,843	68,180	239,091		239,091	(3,455)	235,636			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,210,265	426,469	1,902,931	4,539,665		4,539,665	(63,219)	4,476,446			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,951)	30		9
10	Interest and Other Investment Income	(16,601)	32		10
11	Discounts, Allowances, Rebates & Refunds	(796)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(553)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,090)	21		18
19	Entertainment				19
20	Contributions	(1,450)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,021)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,291)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,725)	20		28
29	Other-Attach Schedule	(38,040)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (125,518)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	62,299		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 62,299		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (63,219)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sterling Pavilion

ID# 0040436

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collection Fees	$ (450)	21	1
2	PPA-Maintenance	(999)	06	2
3	PPA-Nursing Supplies	(504)	10	3
4	PPA-Ancillary Supplies	(3,360)	39	4
5	PPA-Seminar	(320)	24	5
6	PPA-Licenses and Fees	(2,827)	20	6
7	PPA-Insurance	(3,041)	26	7
8	PPA-Employee Benefits	(235)	22	8
9	PPA-Office	(5,497)	21	9
10	PPA-Dietary	(753)	02	10
11	Capitalized R&M	(6,781)	06	11
12	COPE Dues	(1,701)	20	12
13	Non-Allowable Legal Fees	(4,336)	19	13
14	Non-Allowable Travel Expenses	(264)	25	14
15	Bldg Co - Office Expense	(400)	21	15
16	Non-care Asset Depreciation	(6,572)	30	16
17				17
18				18
19				19
20				20
21				21
22				22
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98				98
99				99
100				100
101	Total	(38,040)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(2,102)											(2,102)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			953									953	5
6	Maintenance	(7,780)		1,941	7,232								1,393	6
7	Other (specify):*					609							609	7
8	**TOTAL General Services**	(9,882)		2,894	7,232	609							853	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(504)						(598)					(1,102)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(504)						(598)					(1,102)	16
	C. General Administration													
17	Administrative			(35,000)	109,152								74,152	17
18	Directors Fees													18
19	Professional Services	(4,336)		(258,583)									(262,919)	19
20	Fees, Subscriptions & Promotions	(34,724)		539									(34,185)	20
21	Clerical & General Office Expenses	(15,728)	400	39,972	6,976								31,620	21
22	Employee Benefits & Payroll Taxes	(235)											(235)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(320)		554									234	24
25	Other Admin. Staff Transportation	(264)											(264)	25
26	Insurance-Prop.Liab.Malpractice	(3,041)		1,730									(1,311)	26
27	Other (specify):*			7,090		19,368							26,458	27
28	**TOTAL General Administration**	(58,648)	400	(243,698)	116,128	19,368							(166,450)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(69,034)	400	(240,804)	123,360	19,977		(598)					(166,699)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sterling Pavilion # 0040436 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(36,523)	161,761	3,159									128,397	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,601)	670,233	2,727									656,359	32
33	Real Estate Taxes			3,378									3,378	33
34	Rent-Facility & Grounds		(694,895)										(694,895)	34
35	Rent-Equipment & Vehicles			7,029									7,029	35
36	Other (specify):*		6,667										6,667	36
37	**TOTAL Ownership**	(53,124)	143,766	16,293									106,935	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,360)						(95)					(3,455)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(3,360)						(95)					(3,455)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(125,518)	144,166	(224,511)	123,360	19,977		(693)					(63,219)	45

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 694,895	STERLING BUILDING	100.00%	$	$ (694,895)	1
2	V	32	INTEREST EXPENSE		STERLING BUILDING	100.00%	670,233	670,233	2
3	V	30	DEPRECIATION		STERLING BUILDING	100.00%	161,761	161,761	3
4	V	36	AMORTIZATION		STERLING BUILDING	100.00%	6,667	6,667	4
5	V	21	OFFICE EXPENSE		STERLING BUILDING	100.00%	400	400	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 694,895			$ 839,061	$ * 144,166	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 953	$ 953	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.		1,941	1,941	16
17	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		1,917	1,917	17
18	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		539	539	18
19	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.		39,972	39,972	19
20	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		554	554	20
21	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.		1,730	1,730	21
22	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		7,090	7,090	22
23	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.		3,159	3,159	23
24	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.		2,727	2,727	24
25	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		3,378	3,378	25
26	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		7,029	7,029	26
27	V	19	BOOKKEEPING SERVICES	260,500				(260,500)	27
28	V	17	MANAGEMENT FEES	35,000				(35,000)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 295,500			$ 70,989	$ * (224,511)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 7,232	$ 7,232	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.		16,958	16,958	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.		18,790	18,790	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.		20,272	20,272	18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.				19
20	V	17	ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTH CARE CONS.		10,884	10,884	20
21	V	17	ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		8,877	8,877	21
22	V	17	ADMIN. CMP. - S. LEVY		DYNAMIC HEALTH CARE CONS.		15,208	15,208	22
23	V	17	ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTH CARE CONS.				23
24	V	17	ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTH CARE CONS.		18,163	18,163	24
25	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.		6,976	6,976	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 123,360	$ * 123,360	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 609	$ 609	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.		1,375	1,375	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.		2,076	2,076	17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.		5,814	5,814	18
19	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.				19
20	V	27	EMP. BEN.- S. KOPLIN		DYNAMIC HEALTH CARE CONS.		3,237	3,237	20
21	V	27	EMP. BEN.- D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		836	836	21
22	V	27	EMP. BEN.- S. LEVY		DYNAMIC HEALTH CARE CONS.		2,126	2,126	22
23	V	27	EMP. BEN.- HOWARD ALTER		DYNAMIC HEALTH CARE CONS.				23
24	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.		2,703	2,703	24
25	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.		1,201	1,201	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 19,977	$ * 19,977	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$	$	15
16	V	19	PROFESSIONAL FEES	7,170	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	7,170		16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,170			$ 7,170	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V	10	MEDICAL SUPPLIES	3,180	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	2,582	(598)	16
17	V	39	ANCILLARY EXPENSE	506	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	411	(95)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,686			$ 2,993	$ * (693)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Maurice Aaron	Owner	Administrative	22.23%	See Attached	4.42	8.84%	Allocated	$ 18,790	17-7	1
2	Marshall Mauer	Owner	Administrative	8.26%	See Attached	3.99	7.98%	Allocated	16,958	17-7	2
3	Sue Koplin	Owner	Administrative	0.39%	See Attached	5.98	14.95%	Allocated	10,884	17-7	3
4	Diana Magafas	Owner	Administrative	0.39%	See Attached	4.97	11.04%	Allocated	8,877	17-7	4
5	Dennis Nehmer	Owner	Maintenance	0.39%	See Attached	4.42	11.05%	Allocated	7,232	6-7	5
6	Sharon Aaron	Owner	Clerical	0.39%	See Attached	3.99	9.97%	Allocated	6,976	21-7	6
7	Fred Aaron	Owner	Administrative	23.80%	See Attached	8.00	17.02%	Alloc./Sal	30,772	17-1,17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 100,489		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	427,864	12	$ 9,658	$	42,202	$ 953	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	427,864	12	19,683		42,202	1,941	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	427,864	12	19,431		42,202	1,917	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	427,864	12	5,469		42,202	539	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	427,864	12	405,253	290,672	42,202	39,972	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	427,864	12	5,616		42,202	554	6
7	26	INSURANCE	PATIENT DAYS	427,864	12	17,537		42,202	1,730	7
8	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	427,864	12	71,885		42,202	7,090	8
9	30	DEPRECIATION	PATIENT DAYS	427,864	12	32,025		42,202	3,159	9
10	32	INTEREST	PATIENT DAYS	427,864	12	27,646		42,202	2,727	10
11	33	REAL ESTATE TAXES	PATIENT DAYS	427,864	12	34,248		42,202	3,378	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	427,864	12	71,259		42,202	7,029	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 719,710	$ 290,672		$ 70,989	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	65,436	65,436	4.42	7,232	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	3.99	16,958	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	4.42	18,790	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	119,100	119,100	8.00	20,272	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	24,000	24,000			5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	72,815	72,815	5.98	10,884	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	80,395	80,395	4.97	8,877	7
8	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	152,350	152,350	4.49	15,208	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	9	164,490	164,490	4.97	18,163	10
11	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	69,932	69,932	3.99	6,976	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,100,518	$ 1,100,517		$ 123,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,508		4.42	$ 609	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	13,783		3.99	1,375	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	18,779		4.42	2,076	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	34,154		8.00	5,813	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	25,404				5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	21,655		5.98	3,237	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	7,575		4.97	836	7
8	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	21,295		4.49	2,126	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,244				9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	24,475		4.97	2,703	10
11	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	12,038		3.99	1,201	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 185,910	$		$ 19,976	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION							1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						7,170	2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION							4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,170	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						2,582	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						411	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,993	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Sterling Building, LLC	X		Capitalized Lease			$	$ 6,687,741			$ 670,233	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Manufacturers Bank		X	Line of Credit				424,896			14,830	6
7				Insurance Financing							1,771	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 7,112,637			$ 686,834	9
	B. Non-Facility Related*											
10	Interst Income		X								(16,601)	10
11	Allocated - Dynamic Healthc										2,727	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (13,874)	14
15	TOTALS (line 9+line14)						$	$ 7,112,637			$ 672,960	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 0** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sterling Pavilion **#** 0040436 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 31,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 35,978	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,978	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 38,978	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	28,961	8
	2000	29,219	9
	2001	29,503	10
	2002	30,527	11
	2003	32,600	12

Accrual = 32600 x 1.04

Allocated - Dynamic Healthcare = $3,378

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sterling Pavilion COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0040436

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-402-001	Long Term Care	$ 31,353.48	$ 31,353.48
2.	11-16-402-013	Long Term Care	$ 1,246.62	$ 1,246.62
3.	10-23-404-059-0000	Allocated Home Office	$ 30,261.49	$ 2,984.81
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,861.59	$ 35,584.91

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sterling Pavilion COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0040436

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,000 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 48,888	1
2	Alloc-Bldg Co			100,000	2
3	TOTALS			$ 148,888	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	18,723		20	938	938	10,875	9
10	Various			1994	6,356		20	319	319	3,374	10
11	Various			1995	13,538		20	677	677	6,310	11
12	Various			1996	33,635		20	1,681	(1,681)	13,930	12
13	Various			1997	65,081		20	3,255	3,255	24,146	13
14	Various			1998	86,428		20	4,323	4,323	27,779	14
15	Various			1999	77,777		20	3,858	3,858	22,009	15
16	Various			2000	11,922		20	597	597	2,609	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		6,052,408	155,190		115,190	(40,000)	345,570	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		43,754	1,122		1,250	128	14,168	68
69	Financial Statement Depreciation			16,922			(16,922)		69
70	TOTAL (lines 4 thru 69)		$ 6,409,622	$ 173,234		$ 132,088	$ (44,508)	$ 470,770	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,409,622	$ 173,234		$ 132,088	$ (41,146)	$ 470,770	1
2	Carpeting	2001	934		20	47	47	187	2
3	Tile	2001	558		20	28	28	112	3
4	Sprinkler System Rep	2001	2,002		20	100	100	375	4
5	Dyna Locks	2001	5,085		20	254	254	932	5
6	Overbed Light	2001	1,098		20	55	55	202	6
7	Emergency Lights	2001	365		20	18	18	67	7
8	Smoke Detectors	2001	1,083		20	54	54	198	8
9	Parking Curb	2001	1,023		20	51	51	183	9
10	Door	2001	1,133		20	57	57	199	10
11	Ceiling Tile Install	2001	1,035		20	52	52	181	11
12	Sealer For Parking L	2001	445		20	22	22	78	12
13	Fence	2001	292		20	15	15	52	13
14	Parking Lot Painting	2001	785		20	39	39	141	14
15	Repair Walls	2001	1,285		20	64	64	220	15
16	Doors	2001	527		20	26	26	88	16
17	Circuit Brd-Dynaloc	2001	1,170		20	59	59	186	17
18	Shop Sink Basins	2001	969		20	48	48	153	18
19	Shop Sink Basins	2001	420		20	21	21	67	19
20	Shop Sink Basins	2001	515		20	26	26	79	20
21	Plumbing	2001	532		20	27	27	91	21
22	Tele. Sys.- Tri-City	2001	9,890		20	495	495	1,649	22
23	Garage	2002	54,605		20	5,461	5,461	15,471	23
24	Wall Heater	2002	504		20	50	50	147	24
25	Phone Wiring Garage	2002	950		20	95	95	253	25
26	Wall Vinyl	2002	4,190		20	419	419	1,082	26
27	Refrigerator Compressor	2002	715		20	72	72	185	27
28	Flooring	2002	832		20	83	83	208	28
29	Drain Piping	2002	887		20	89	89	222	29
30	Rooftop Compressors	2002	3,423		20	342	342	856	30
31	Rooftop Compressor	2002	1,502		20	150	150	363	31
32	Keypads For Doors	2002	1,486		20	149	149	372	32
33	Blinds	2002	1,683		20	168	168	421	33
34	TOTAL (lines 1 thru 33)		$ 6,511,545	$ 173,234		$ 140,724	$ (32,510)	$ 495,790	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,511,545	$ 173,234		$ 140,724	$ (32,510)	$ 495,790	1
2	Blinds	2002	340		20	34	34	82	2
3	Blinds	2002	289		20	29	29	70	3
4	Window Treatments	2002	9,612		20	961	961	2,243	4
5	Circuit Board Security	2002	1,256		20	126	126	293	5
6	Countertops	2002	1,925		20	193	193	449	6
7	Wall Vinyl	2002	1,294		20	129	129	291	7
8	Fireplace	2002	1,761		20	176	176	396	8
9	Handrails & Bumpers	2002	4,624		20	462	462	963	9
10	Painting	2002	533		20	53	53	133	10
11	Wallpaper	2002	585		20	59	59	151	11
12	Wallpaper	2002	2,436		20	244	244	609	12
13	Ac Repairs	2002	545		20	55	55	141	13
14	Ac Repairs	2002	1,708		20	171	171	399	14
15	Valve Repairs	2002	981		20	98	98	213	15
16	Motor	2002	1,200		20	120	120	250	16
17	Doors	2003	5,532		20	553	553	1,014	17
18	Remodel Bathroom	2003	1,418		20	142	142	260	18
19	Bathroom Remodeling	2003	8,563		20	856	856	1,570	19
20	Floor Tile	2003	1,472		20	147	147	270	20
21	Overbed Lights	2003	651		20	65	65	108	21
22	Window Treatments	2003	3,269		20	327	327	545	22
23	Rewire Fire Panel	2003	2,132		20	213	213	320	23
24	Door Contacts For Wanderguard Sys	2003	2,942		20	294	294	368	24
25	2 Entrance & Doors	2003	10,605		20	1,061	1,061	1,326	25
26	Variance On 2001 Asset	2003	(2,085)		20	(209)	(209)	(417)	26
27	Condensor Repairs	2003	505		20	51	51	76	27
28	Generator	2003	833		20	83	83	90	28
29	Heating Repairs	2003	1,670		20	167	167	181	29
30	Heating Repairs	2003	2,431		20	243	243	263	30
31	Remodel Bathroom	2004	2,794		20	279	279	279	31
32	Remodel Bathroom	2004	4,713		20	432	432	432	32
33	Remodel Bathroom	2004	4,310		20	395	395	395	33
34	TOTAL (lines 1 thru 33)		$ 6,592,389	$ 173,234		$ 148,733	$ (24,501)	$ 509,553	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,592,389	$ 173,234		$ 148,733	$ (24,501)	$ 509,553	1
2	Tile For Bathroom Remodel	2004	1,155		20	116	116	116	2
3	Mixing Valve For Water System	2004	964		20	72	72	72	3
4	Black Top Entrance	2004	4,700		20	353	353	353	4
5	2 Hot Water Heaters	2004	8,691		20	362	362	362	5
6	Condensing Unit	2004	4,903		20	204	204	204	6
7	A/C & Hot Water Heater	2004	4,111		20	171	171	171	7
8	Parts Fro Install Of Hot Water Heaters	2004	1,302		20	54	54	54	8
9	Parts For Install Of Hot Water Heaters	2004	1,452		20	48	48	48	9
10	Generator Board	2004	2,077		20	35	35	35	10
11	Hosp. Inc. Tile	2004	1,112		20	19	19	19	11
12	Refrigerator - Walk In Freezer	2004	4,500		20	38	38	38	12
13	Motor, Thermostats, Capacitors, Blower Motors	2004	1,515		20	76	76	76	13
14	12 Overbed Lights With Pull Chain	2004	1,191		20	60	60	60	14
15	12 Overbed Lights With Pull Chain	2004	1,131		20	57	57	57	15
16	Alarm - Tone Generator	2004	594		20	30	30	30	16
17	Leak Repair And Control Valve	2004	703		20	35	35	35	17
18	Motor	2004	952		20	48	48	48	18
19	10 Thermostats	2004	695		20	35	35	35	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	1
2									2
3									3
4									4
5									5
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	1
2									2
3									3
4									4
5									5
6									6
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10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	1
2									2
3									3
4									4
5									5
6									6
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8									8
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10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,634,137	$ 173,234		$ 150,544	$ (22,690)	$ 511,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1994		$ 6,052,408	$ 155,190	35	$ 115,190	$ (40,000)	$ 345,570	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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10											10
11											11
12											12
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14											14
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,052,408	$ 155,190		$ 115,190	$ (40,000)	$ 345,570	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated		1993	1993	$ 43,754	$ 1,122	35	$ 1,250	$ 128	$ 14,168	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 43,754	$ 1,122		$ 1,250	$ 128	$ 14,168	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 312,318	$ 19,260	$ 32,196	$ 12,936	10	$ 178,343	71
72	Current Year Purchases	16,201	16,201	1,762	(14,439)	10	1,762	72
73	Fully Depreciated Assets	393,778				10	30,778	73
74								74
75	TOTALS	$ 722,297	$ 35,461	$ 33,958	$ (1,503)		$ 210,883	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	BUS	2000	$ 45,441	$ 5,235	$	$ (5,235)	5	$ 45,441	76
77	Allocated - Dynamic	auto - allocated	2004	5,533	634	111	(523)	5	111	77
78										78
79										79
80	TOTALS			$ 50,974	$ 5,869	$ 111	$ (5,758)		$ 45,552	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,556,296	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 214,564	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,613	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,951)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 767,799	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BUILDING - 2004	$ 256,308	$ 6,572	$	86
87	LAND - 2004	4,235			87
88					88
89					89
90					90
91	TOTALS	$ 260,543	$ 6,572	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,666 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Dynamic		$	$ 6,943	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,943	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 61,900		$	$		$ 61,900	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,750			1,750	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	34,168					34,168	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				64,880		64,880	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						9,963		9,963	13
14	TOTAL			$ 96,068		$ 1,750	$ 74,843		$ 172,661	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,771	$ 2,797	1
2	Cash-Patient Deposits	35,978	35,978	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	690,046	690,046	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,257	31,257	6
7	Other Prepaid Expenses	2,373	2,373	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify): See Attached Schedule	30,024	42,124	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 992,449	$ 1,004,575	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	48,887	153,122	13
14	Buildings, at Historical Cost		6,308,716	14
15	Leasehold Improvements, at Historical Cost	459,057	459,057	15
16	Equipment, at Historical Cost	383,074	746,074	16
17	Accumulated Depreciation (book methods)	(441,133)	(2,454,272)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	6,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(6,498)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	229,900	29,996	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 679,785	$ 5,242,693	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,672,234	$ 6,247,268	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 209,456	$ 65,290	26
27	Officer's Accounts Payable	87,500	87,500	27
28	Accounts Payable-Patient Deposits	35,978	35,978	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	234,840	234,840	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,937	1,937	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,000	34,000	32
33	Accrued Interest Payable	1,607	1,607	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,192	9,192	35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 614,510	$ 470,344	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	424,896	424,896	39
40	Mortgage Payable		6,687,741	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 424,896	$ 7,112,637	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,039,406	$ 7,582,981	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 632,828	$ (1,335,713)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,672,234	$ 6,247,268	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 613,910	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 613,910	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	164,118	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(145,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 18,918	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 632,828	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,631,531	1
2	Discounts and Allowances for all Levels	(544,294)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,087,237	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	473,700	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 473,700	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	97,322	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,013	19
20	Radiology and X-Ray	3,098	20
21	Other Medical Services	6,703	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 115,136	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,602	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,602	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,108	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,108	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,703,783	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	840,113	31
32	Health Care	1,679,384	32
33	General Administration	975,185	33
	B. Capital Expense		
34	Ownership	805,892	34
	C. Ancillary Expense		
35	Special Cost Centers	172,661	35
36	Provider Participation Fee	66,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,539,665	40
41	**Income before Income Taxes (line 30 minus line 40)****	164,118	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 164,118	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,018	2,131	$ 63,577	$ 29.83	1
2	Assistant Director of Nursing	802	829	18,687	22.54	2
3	Registered Nurses	6,992	7,455	155,251	20.83	3
4	Licensed Practical Nurses	20,927	22,698	415,730	18.32	4
5	Nurse Aides & Orderlies	70,255	74,646	728,193	9.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,449	1,783	96,068	53.88	7
8	Rehab/Therapy Aides	3,583	3,583	44,783	12.50	8
9	Activity Director	2,604	2,723	29,348	10.78	9
10	Activity Assistants	8,344	8,830	66,633	7.55	10
11	Social Service Workers	3,848	3,988	44,583	11.18	11
12	Dietician					12
13	Food Service Supervisor	2,058	2,259	25,989	11.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,252	20,102	132,021	6.57	15
16	Dishwashers					16
17	Maintenance Workers	3,885	4,247	51,587	12.15	17
18	Housekeepers	14,868	16,126	116,553	7.23	18
19	Laundry	7,748	8,269	53,928	6.52	19
20	Administrator	2,010	2,099	90,273	43.01	20
21	Assistant Administrator					21
22	Other Administrative	416	416	10,500	25.24	22
23	Office Manager					23
24	Clerical	3,251	3,431	41,391	12.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,853	1,995	17,615	8.83	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	795	875	7,555	8.63	33
34	TOTAL (lines 1 - 33)	176,958	188,485	$ 2,210,265 *	$ 11.73	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 7,080	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	171	6,830	10-03	39
40	Physical Therapy Consultant	Monthly	2,345	10a-03	40
41	Occupational Therapy Consultant	Monthly	4,274	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	154	9,005	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	517	$ 29,534		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Reed	Administrator		$ 90,273
Fred Aaron	Administrative	23.80%	10,500
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 100,773

B. Administrative - Other

Description	Amount
Dynamic Healthcare Consultants	$ 35,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 35,000

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 12,523
Sachnoff & Weaver	Legal	23,308
Seyfarth Shaw	Legal	30,393
Ward, Murray, Pace & Johnson	Legal	3,773
Health Data Systems	Data Processing	4,310
Dynamic Healthcare Cons.	Bookkeeping Services	260,500
Robinson and Associates	Computer Support	2,415
Econocare, Inc	Purchasing Consultant	2,178
Personnel Planners	Unemployment Cons.	1,728
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 341,128

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,256
Unemployment Compensation Insurance	18,055
FICA Taxes	168,558
Employee Health Insurance	32,277
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,296
TOTAL (agree to Schedule V, line 22, col.8)	$ 289,442

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,236
Health Care Worker Background Check	1,076
(Indicate # of checks performed 90)	
Licenses and Fees	2,363
Dues and Subscriptions	5,494
Advertising and Promotional	28,746
Allocated - Dynamic Healthcare	539
Less: Public Relations Expense	( )
Non-allowable advertising	(27,021)
Yellow page advertising	(1,725)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,708

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,032
Allocated - Dynamic Healthcare	554
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,586

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion **#** 0040436 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC-$5494**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,265** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,430**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.